OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT (OSHPD)
STATE LOAN REPAYMENT PROGRAM

CERTIFIED ELIGIBLE SITE APPLICATION

I. PRACTICE SITE INFORMATION

Please complete one Application per practice site.

Check One Only : **Primary Medical Care Site** _____ **Dental Care Site** _____
Mobile Medical Unit _____ **Mobile Dental Unit** _____

1. **Name of Practice Site** : _____

Street Address : _____
Number Street P.O. Box

_____
City State Zip + 4

County : _____

2. **Description of Practice Site** : _____
[e.g., 330 Clinic, 329 Migrant Health Center, 95-210 Clinic, 638 Tribal Clinic, FQHC, District Hospital Clinic, County Owned Clinic, etc.]

3. **Type of Practice** : Public_____
Private Not-For-Profit_____ **[Attach Federal tax exempt letter-i.e., 501(c)(3)]**

4. **Name of Sponsoring Entity** : _____

Street Address : _____
Number Street P.O. Box

_____
City State Zip + 4

5. **Name of Entity Contact Person** : _____ Telephone: _____

Title : _____ Fax No.: _____

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II. PRACTICE SITE ASSURANCES

Entity contact person must initial all requirements with which agency intends to comply.

1. Loan Repayments:

——— • Site shall match OSHPD's award for loan repayment on a 50-50 basis and shall pay with non-federal funds (i.e., revenues from State or local government and the private sector, no part of which represents an appropriation of federal monies).

2. Salaries:

——— • Site shall compensate providers at salaries that are competitive with other health professional salaries in the area.

——— • Site shall not use OSHPD's award or the site match as a means to reduce provider salaries or offset provider salaries (e.g., deduct funds from provider's paychecks).

3. Accessibility:

——— • Providers will accept assignment for Medicare and Medicaid patients.

——— • Site uses sliding discount fee schedule or other documented means that assures no financial barriers to care for those below 200% poverty.

——— • Site will conspicuously post a statement of nondiscrimination based on ability to pay.

——— • Site has a nondiscrimination policy that prohibits discrimination based on race, age, creed, disability or religion.

4. Comprehensive System of Care**:**

——— • Providers shall practice in dental care settings or in ambulatory primary care settings that assure the availability of primary care services, including lab and x-ray, pharmacy, after-hours, and referral arrangements for services not available on site.

5. Quality of Care:

——— • Site has a credentialing program in place to review references and verify licensure and certification status of all providers.

——— • Site has an improvement system in place, which may include patient satisfaction surveys, peer review systems, clinical outcome measures or similar systems.

——— • Services will be delivered in a culturally appropriate fashion so as to be sensitive and responsive to the needs of the target population.

——— • Site will address retention of providers through monitoring of turnover, clinical team management efforts, pay comparability surveys, exit interviews, and other means.

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II. PRACTICE SITE ASSURANCES (Cont'd.)

6. Provider Employment Contracts:

- _____ • Providers shall practice only in the approved HPSA and at the site to which originally assigned, for a minimum of two (2) years, unless a change is approved by OSHPD.
- _____ • All providers will have contracts or employment agreements that include the following: Providers shall perform full-time clinical practice which is defined as a minimum of 40 hours per week and a minimum of 45 weeks per year (1800 hours).
- _____ • Contract shall not restrict the continued practice of provider in the HPSA to which he/she is assigned, after his/her obligation is completed.
- _____ • Continuing professional education time and funds shall be made available.
- _____ • Site shall communicate with OSHPD staff regarding the status of providers, including resignations, terminations and extended leave for providers.
- _____ • Site shall inform OSHPD of all circumstances surrounding resignations & terminations.
- _____ • Site must immediately inform OSHPD if it is no longer willing or able to comply with any of the above conditions.

III. PRACTICE SITE CERTIFICATION

I certify that the information provided in this application is true and correct as of the date set forth opposite my signature. I also understand that any intentional or negligent misrepresentation(s) of the information contained in this application may result in the forfeiture of our entity's eligibility to participate in the State Loan Repayment Program.

Name: _____

Title: _____ Phone No.: _____

Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE

App. Received: _____ Census Tract No.:_____ HPSA No.: _____

Comments: _____

_____

Return to: Office of Statewide Health Planning and Development, Healthcare Workforce and Community Development Division, State Loan Repayment Program, 1600 9th St., Room 440, Sacramento, CA 95814, Attn: Karen Munsterman.